



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Texas Spine & Joint Hospital

Respondent Name

Hartford Underwriters Insurance

MFDR Tracking Number

M4-16-3618-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

August 5, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is our position that the bill has been coded correctly with all proper codes, and that the Hospital is entitled to reimbursement. Not only did the Hospital code the bill properly, it also timely billed The Hartford and provided the medically necessary, authorized procedure to the patient."

Amount in Dispute: \$9,059.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our investigation has found: Billing was processed in accordance with Rule 134.403. Pharmacy, injections and supplies are inclusive. CPT 99070 & 27096 not paid under Medicare OPPS."

Response Submitted by: The Hartford, 300 S. State St., One Park Place, Syracuse, NY 13202

SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|------------------|------------------------------|-------------------|------------|
| August 7, 2015 | Outpatient Hospital Services | \$9,059.00 | \$314.50 |

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for services provided in outpatient hospital services.
3. 28 Texas Administrative Code §133.200 sets out requirements of insurance carrier receipt of medical bills

from health care providers.

4. 28 Texas Administrative Code §133.2 defines complete medical bill.
5. 28 Texas Administrative Code §133.10 sets out requirements for completion of billing forms.
6. Texas Administrative Code §133.240 sets out requirements of medical payments and denials.
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
 - 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed
 - 797 – Service not paid under Medicare OPPS

Issues

1. Did the carrier evaluate and return the original bill?
2. Was the carrier required to take final action on the bill within 45 days?
3. Do the codes on the explanation of benefits match submitted codes on bill?
4. What is the applicable fee pertaining to reimbursement?
5. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor states in their position statement in relevant part, “...I called The Hartford on June 29, 2016 and was informed that the bill was never processed, so there was no Explanation of Review generated. I was also informed by The Hartford’s representative that the bill was not processed because it did not have the correct Medicare accepted CPT codes on the UB04.” 28 Texas Administrative Code §133.200 (a)(2)(B) states,

Upon receipt of medical bills submitted in accordance with §133.10(a)(1) and (2) of this chapter (relating to Required Medical Forms/Formats), an insurance carrier shall evaluate each medical bill for completeness as defined in §133.2 of this chapter (relating to Definitions).

(2) Within 30 days after the day it receives a medical bill that is not complete as defined in §133.2 of this chapter, an insurance carrier shall:

(B) return the bill to the sender, in accordance with subsection (c) of this section.

28 Texas Administrative Code §133.200 (b) states,

An insurance carrier shall not return a medical bill except as provided in subsection (a) of this section. When returning a medical bill, the insurance carrier shall include a document identifying the reason(s) for returning the bill. The reason(s) related to the procedure or modifier code(s) shall identify the reason(s) by line item.

No evidence was presented by the respondent to refute or support the return of the original claim based on “correct Medicare accepted CPT codes on the UB04.” Therefore the Division finds the respondent did not meet the requirements of Rule 133.200.

2. Texas Administrative Code §133.240 (a) states,

An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation.

No evidence was found to support the return of a non-complete medical bill therefore, the carrier was required to process the original claim within 45 days of the receipt of the complete medical bill.

While a document dated August 12, 2016 was submitted indicating “INVOICE IS ILLEGIBLE,” this date is after the explanation of benefits that was processed on August 3, 2016 that denied all charges. This document was considered but will not affect the review of the services in dispute.

3. Review of the explanation of benefits finds the following CPT codes/Revenue codes: J3010, J2250, J1030, 250, J7030, 99070, 270, 370, Q9967, 710, 27096, and 761. Review of the health care provider’s claim shows the following CPT codes/Revenue codes: J3010, J2250 J1030, 250, J7030, 96365, 270, 370, Q9967, 710, 27096, and 761. 28 Texas Administrative Code §133.200(a)(2)(A)(ii) states in pertinent part,

(2) Within 30 days after the day it receives a medical bill that is not complete as defined in §133.2 of this chapter, an insurance carrier shall:

- (A) complete the bill by adding missing information already known to the insurance carrier, except for the following:
 - (i) dates of service;
 - (ii) procedure/modifier codes;

Review of the submitted medical claim(s) finds that health care provider billed CPT code 96365. No documentation was found to support that the health care provider billed for CPT Code 99070 which was audited by the insurance carrier. As a result CPT Code 96365 will be reviewed per applicable rules and fee guidelines.

4. The services in dispute are for outpatient hospital services and are therefore subject to the requirements of 28 Texas Administrative Code 134.403 (d) which states in pertinent part, “For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided...” The applicable Medicare payment policy may be found at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS.

In order to calculate the correct Division fee guideline, stakeholders should be familiar with the main components in the calculation of the Medicare payment for OPSS services which are:

- **How Payment Rates Are Set**, found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctshsht.pdf,
 - *To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted.*
- **Payment status indicator** - The status indicator identifies whether the service described by the HCPCS code is paid under the OPSS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPSS or under another payment system or fee schedule. The relevant status indicator may be found at the following: www.cms.gov, Hospital Outpatient Prospective Payment – Final Rule, OPSS Addenda, Addendum D1.
- **APC payment groups** - Each HCPCS code for which separate payment is made under the OPSS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. The relevant payment amount for each APC may be found at: www.cms.gov, Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files, Addendum B. These files are updated quarterly.

- **Medicare Claims Processing Manual, Chapter 4, Section 20 - Reporting Hospital Outpatient Services Using Healthcare Common Procedure Coding System (HCPCS)** - The HCPCS codes are required for all outpatient hospital services unless specifically excepted in manual instructions. This means that codes are required on surgery, radiology, other diagnostic procedures, clinical diagnostic laboratory, durable medical equipment, orthotic-prosthetic devices, take-home surgical dressings, therapies, preventative services, immunosuppressive drugs, other covered drugs, and most other services. When medical and surgical supplies (other than prosthetic and orthotic devices as described in the Medicare Claims Processing Manual, Chapter 20, §10.1) described by HCPCS codes with status indicators other than “H” or “N” are provided incident to a physician's service by a hospital outpatient department, the HCPCS codes for these items should not be reported because these items represent supplies. Claims containing charges for medical and surgical supplies used in providing hospital outpatient services are submitted to the Medicare contractor providing OPPS payment for the services in which they are used. The hospital should include charges associated with these medical and surgical supplies on claims so their costs are incorporated in ratesetting, and payment for the supplies is packaged into payment for the associated procedures under the OPPS in accordance with 42 CFR 419.2(b)(4).

28 Texas Administrative Code §134.403 (f) states in pertinent part,

The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

(1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

(A) 200 percent;

The services in dispute is reimbursed based on the following:

| Submitted code | Status Indicator | APC | Payment Rate | Unadjusted labor amount = APC payment x 60% | Geographically adjusted labor amount = unadjusted labor amount x annual wage index | Non labor portion = APC payment rate x 40% | Medicare facility specific reimbursement (geographically adjusted labor) amount + non labor portion) | Maximum Allowable Reimbursement |
|----------------|------------------|------|--------------|---|--|--|--|------------------------------------|
| 96365 | S | 0439 | \$173.59 | $\$173.59 \times 60\% = \104.15 | $\$104.15 \times 0.8431 = \87.81 | $\$173.59 \times 40\% = \69.44 | $\$87.81 + \$69.44 = \$157.25$ | $\$157.25 \times 200\% = \314.50 |
| | | | | | | | Total | \$314.50 |

- Procedure code J3010 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2250 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1030 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J7030 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code Q9967 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

- Procedure code 27096 has status indicator B denoting codes that are not recognized by OPPS when submitted on an outpatient hospital bill. Reimbursement is not recommended.
5. The maximum allowable reimbursement for the eligible service is \$314.50. The carrier paid \$0.00. The remaining balance of \$314.50 is due to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$314.50.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$314.50, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

| | | |
|-----------|--|--------------------|
| _____ | _____ | September 21, 2016 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.